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IN THE

# Supreme Court of the United States

BANK OF LOUISIANA, PETITIONER

*v.*

AETNA US HEALTHCARE, INC. AND AETNA LIFE INSURANCE COMPANY

*PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES CIRCUIT COURT OF APPEALS FOR THE FIFTH CIRCUIT*

## PETITION FOR WRIT OF CERTIORARI

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## QUESTIONS PRESENTED

1. Does ERISA preempt the petitioner's state claims for breach of contract against Aetna, its stop-loss insurance carrier, for failing to honor a written promise to reimburse the petitioner for employee claims it paid under its self funded benefit plan during the three-month "run-out" period covered by the stop-loss insurance it purchased from Aetna?

2. Should this Court resolve the split of opinion among the federal courts about whether an employer's state law claims against its stop-loss insurance carrier seeking to enforce the stop-loss insurance agreement are preempted by ERISA?

3. Should this Court construe the provisions of ERISA to allow for an award of compensatory damages to an employer when its stop-loss insurance carrier through malfeasance, negligence or deliberate choice breaches the stop-loss insurance agreement to reimburse the employer for the employee benefit claims it paid during the three-month "run-out" period?

4. Should small and medium-size businesses who purchase stop-loss insurance for their fully self funded employee benefit plans have the right to enforce its provisions by bringing state law claims against the stop-loss insurance carrier?

## TABLE OF CONTENTS

Page

QUESTIONS PRESENTED ..... i

TABLE OF AUTHORITIES ..... iii

OPINIONS BELOW ..... 1

JURISDICTION ..... 2

RELEVANT PROVISIONS INVOLVED ..... 2

STATEMENT ..... 7

REASONS FOR GRANTING THE PETITION ..... 17

CONCLUSION ..... 24

APPENDIX

*Fifth Circuit Court of Appeals Opinion* ..... 1a

*District Court Opinion* ..... 16a

*District Court Opinion* ..... 22a

*Fifth Circuit Court of Appeals Opinion on Rehearing* ..... 30a

# TABLE OF AUTHORITIES

Page

**CASES**

AETNA HEALTH INC. v. DAVILA, 542 U.S. 200, 222-224(2004) ..... 23

BILL GRAY ENTERPRISES, INC. EMP. H. & W. v. GOURLEY, 248 F.3D 206, 213-214(3RD CIR. 2001) ..... 21

CALIFORNIA DIV. OF LABOR STAND. ENF. v. DILLINGHAM CONSTRUCTION, N.A., INC., 519 U.S. 316 (1997) ..... 23

CICIO v. DOES, 321 F. 3D 83, 106-110(2D CIR 2003) ..... 22-23

COMPUTER AIDED DESIGN SYSTEMS v. SAFECO LIFE INS., 235 F. SUPP. 2D 1052, 1057(S.D. IOWA 2002 ..... 21

DIFELICE v. AETNA US HEALTHCARE, 346 F. 3D 442, 459(3RD CIR. 2003) ..... 22

GEWEKE FORD v. ST. JOSEPH'S OMNI PREF. CARE, INC., 130 F.3D 1355, 1359-1360(9TH CIR. 1997) ..... 20

FMC CORP. HOLLIDAY, 498 U.S. 52, 58(1990) ..... 17, 18

GREAT WEST LIFE & ANNUITY INS. CO. v. KNUDSON, 534 U.S. 204, 210-215(2002) ..... 22, 23

MERTENS v. HEWITT ASSOCIATES, 508 U.S. 248, 360-261(1993) ..... 22

METROPOLITAN LIFE INS. CO. v. MASSACHUSETTS, 471 U.S. 724, 739-743(1985) ..... 18

NORTHERN GROUP SERVS., INC. v. AUTOMOBILE

OWNERS INS. CO., 833 F.2D 85, 91(6TH CIR. 1987). ..... 20-21

NORTHERN KARE FACILITIES V. BENEFIRST, LLC, 344 F. SUPP. 2D 283, 286-289(D. MASS. 2004) ..... 21

OUTSOURCING, INC. V. COMMERCE BENEFITS GROUP AGENCY, INC., 54 F. SUPP. 2D 566, 573(W.D.N.C 1999) ..... 21

PILOT LIFE INS. CO. V. DEDEAUX, 481 U.S. 41, 48(1987) ..... 18, 23

SENECA BEVERAGE CORP. V. HEALTHNOW OF NEW YORK, 383 F. SUPP.2D 413 (W.D.N.Y. 2005) ..... 21

SHAW V. DELTA AIRLINES, INC., 463 U.S. 85, 98(1983) ..... 17

THOMPSON V. TALQUIN BLDG. PRODUCTS CO., 928 F.2D 649, 653(4TH CIR. 1991). ..... 21

TRI-STATE MACH., INC. V. NATIONWIDE LIFE INS. CO., 33 F.3D 309, 315(4TH CIR. 1994). ..... 21

UNION HEALTH CARE, INC. V. JOHN ALDEN LIFE INS. CO., 908 F. SUPP. 429, 431(S.D. MISS. 1995) ..... 21

WORKFORCE DEVELOPMENT V. CORPORATE BEN. SERVICES, 316 F. SUPP.2D 854, 858(D. MINN. 2004) ..... 21

**STATUTES**

28 U.S.C. SECTION 1254(1) ..... 2

28 U.S.C. SECTION 2101(C) ..... 2

29 U.S.C. SECTION 1001 ..... 12

29 U.S.C. SECTION 1001(B) ..... 2

29 U.S.C. SECTION 1002(1) ..... 3

29 U.S. C. SECTIONS 1109 ..... 14

29 U.S.C. SECTION 1132(A)(1)-(5) ..... 4

29 U.S.C. SECTION 1144 ..... 5, 13

29 U.S.C. SECTION 1144(A) ..... 17

29 U.S.C. SECTION 1132(A)(3) ..... 14

29 U.S.C. SECTION 1144(B)(2)(A) ..... 17

29 U.S.C. SECTION 1144(B)(2)(B) ..... 18

LA. REV. ST. SECTION 22:657 ..... 13, 14, 15

LA. REV. STAT. 22:657(A) ..... 6

LA. REV. ST. SECTION 22:658 ..... 14

LA. REV. STAT. 22:658(A)(1) ..... 7

## OPINIONS BELOW

The published opinion of the Court of Appeals for the Fifth Circuit in *Bank of Louisiana v. Aetna US Healthcare, Inc. and Aetna Life Insurance Company*, Docket No. 04-30986, reported at 459 F.3d 610 and filed on August 4, 2006, reversing the District Court's entry of summary judgment against the petitioner, is set forth in the Appendix hereto(App. 1-15).

The unpublished Order and Reasons of the United States District Court for the Eastern District of Louisiana, in *Bank of Louisiana v. Aetna US Healthcare, Inc. and Aetna Life Insurance Company*, Civil Action No. 02-236, dated September 8, 2004, granting the respondent's motion for summary judgment, is set forth in the Appendix hereto(App.16-21).

The unpublished Order and Reasons of the United States District Court for the Eastern District of Louisiana, in *Bank of Louisiana v. Aetna US Healthcare, Inc. and Aetna Life Insurance Company*, Civil Action No. 02-236, dated July 9, 2003, dismissing the petitioner's state law claims as preempted under ERISA, is set forth in the Appendix hereto(App. 22-29).

The unpublished opinion of the Court of Appeals for the Fifth Circuit in *Bank of Louisiana v. Aetna US Healthcare, Inc. and Aetna Life Insurance Company*, Docket No. 04-30986, filed on October 18, 2006, in response to the respondent's petition for rehearing, withdrawing the prior panel opinion and substituting a new opinion qualifying its earlier reversal of the

District Court's entry of summary judgment against the petitioner, is set forth in the Appendix hereto(App. 30-44).

## JURISDICTION

The final opinion of the United States Court of Appeals for the Fifth Circuit reversing in part the District Court's entry of summary judgment against the petitioner was entered on October 18, 2006(App. 30).

This petition for writ of certiorari by the Petitioners is filed within ninety (90) days of that date. 28 U.S.C. Section 2101(c).

The jurisdiction of this Court is invoked pursuant to the provisions of 28 U.S.C. Section 1254(1).

## RELEVANT PROVISIONS INVOLVED

**United States Constitution, Amendment V:**

No person shall...be deprived of life, liberty, or property, without due process of law....

**29 U.S.C. Section 1001(b):**

**(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries**

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

**29 U.S.C. Section 1002(1) and 21(a):**

**Definitions**

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise,

(A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or

(B) any benefit described in section 186 (c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

.....

(21)

(A) Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent

(i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting

management or disposition of its assets,

(ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or

(iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 1105 (c)(1)(B) of this title.

**29 U.S.C. Section 1132(a)(1)-(5) (Section 502 of ERISA):**

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate

relief under section 1109 of this title;
(3) by a participant, beneficiary, or fiduciary
(A) to enjoin any act or practice which violates any provision of this subchapter
or the terms of the plan, or
(B) to obtain other appropriate equitable relief
(i) to redress such violations or
(ii) to enforce any provisions of this subchapter or the terms of the plan;
(4) by the Secretary, or by a participant, or beneficiary for appropriate relief
in the case of a violation of 1025(c) of this title;
(5) except as otherwise provided in subsection (b) of this section, by the Secretary
(A) to enjoin any act or practice which violates any provision of this subchapter, or
(B) to obtain other appropriate equitable relief
(i) to redress such violation or
(ii) to enforce any provision of this subchapter....

**29 U.S.C. Section 1144 (Section 514 of ERISA):**

(a) Supersedure; effective date
Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003 (a) of this title and not exempt under section 1003 (b) of this title. This section shall take effect on January 1, 1975.
(b) Construction and application
.....
(2) (A) Except as provided in subparagraph (B),

nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003 (a) of this title, which is not exempt under section 1003 (b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

**Louisiana Rev. Stat. 22:657(A):**

All claims arising under the terms of health and accident contracts issued in this state, except [accidental death claims], shall be paid not more than thirty days from the date upon which written notice and proof of claim, in the form required by the terms of the policy, are furnished to the insurer unless just and reasonable grounds, such as would put a reasonable and prudent businessman on guard, exist....Failure to comply with the provisions of this Section shall subject the insurer to a penalty payable to the insured of double the amount of the accident and health benefits due under the terms of the policy or contract during the period of delay, together with attorney's fees to be

determined by the court....

**Louisiana Rev. Stat. 22:658(A)(1) & (B)(1):**

A. (1) All insurers issuing any type of contract, other than those specified in R.S. 22:656, 22:657..., shall pay the amount of any claim due any insured within thirty days after receipt of satisfactory proofs of loss from the insured or any party in interest....

....

B. (1) Failure to make such payment within thirty days after receipt of such satisfactory proofs...shall subject the insurer to a penalty, in addition to the amount of the loss, of fifty percent damages on the amount found to be due from the insurer to the insured, or one thousand dollars, whichever is greater, payable to the insured, or to any of said employees, or in the event a partial payment or tender has been made, fifty percent of the difference between the amount paid or tendered and the amount found to be due as well as reasonable attorney's fees and costs....

## STATEMENT

In 1995, the petitioner Bank of Louisiana ("the petitioner" or "BOL") fully self funded its employee health insurance plan, either by setting aside funds to satisfy potential claims against the plan or by paying benefits to plan participants out of BOL's general accounts. In order to reduce the risk of substantial financial loss which attends the self-funding of a health insurance plan for its employees, the petitioner

purchased from the respondent Aetna Life Insurance Company, later the respondent Aetna US Healthcare, Inc. ("the respondent" or "Aetna"), a form of reinsurance known as stop-loss insurance.

Stop-loss insurance is a way for an employer who self funds a health or other welfare plan for its employees to insure against the risk of excessive payouts and to limit its consequent liability. It also levels out the peaks and valleys of the loss experience and thereby helps to stabilize costs. The stop-loss contract specifies an effective date, a so-called "run-in" period immediately prior to the effective date when claims can be covered and a so-called "run-out" or "run-off"period immediately after the plan period when claims can be covered. Coverage may begin once an individual claim surpasses a high deductible called the individual stop-loss amount; or when year-to-date aggregate claims surpass a pre-negotiated amount, usually 125 percent of actuarially derived expected losses in aggregate for the plan year, called the aggregate stop-loss amount.

When the petitioner purchased stop-loss insurance from Aetna in January of 1995, it agreed to be responsible for the first $50,000 of health-care costs incurred by any individual employee during the calendar year with Aetna being responsible for any claims which exceeded this amount for any individual employee in a calendar year. In addition, BOL was responsible for a sum certain in aggregate claims for the calendar year with Aetna being responsible for any claims beyond this aggregate amount. Finally, it was agreed that Aetna would administer BOL's self-funded employee benefit plan pursuant to an administrative

services contract.

In the summer of 2000, Aetna announced that it would no longer provide stop-loss insurance for the petitioner and it encouraged BOL to cease self funding its employee benefit plan and instead purchase a fully insured benefit plan from Aetna for the year 2001, a purchase which BOL decided to make. In the meantime, by November of 2000, BOL had reached its aggregate stop-loss limit in claims and consistent with the stop-loss insurance it had purchased from Aetna, Aetna was responsible for any claims beyond this amount incurred in the year 2000.

Because claims incurred in 2000 but not presented for payment until 2001 were not covered by BOL's stop-loss insurance with Aetna and in order to have Aetna pay those claims even though not presented until 2001, the petitioner on December 1, 2000, paid Aetna a premium of $36,132.78 to purchase a "tail" to its stop-loss policy and thereby obligate Aetna to pay "run-out" claims under the 2000 plan for three months after the 2000 stop-loss insurance expired on December 31, 2000.

On December 28, 2000, Aetna's Account Manager (Ms. Stacy McMahon) then warranted the petitioner in writing that BOL would have no further exposure for claims originating in the year 2000 if it purchased this "tail" coverage from Aetna. In her letter responding to the petitioner's request for written affirmation of the scope of such coverage, she wrote BOL:

> [p]er your request, this is confirmation that the Bank of Louisiana met the Aggregate Stop Loss limit for the 2000 contract year. According to your contract with us, the bank will have no additional claim liability for 2000 and no additional fund transfers will be requested. Beginning January 1, 2001, your runoff ["run-out"] period will begin, at which time the monthly budgeting feature will no longer exist. We will start wiring your account for claims paid during the runoff period *and you will be reimbursed at year end.*

(emphasis supplied).

As an accommodation by BOL and based upon its understanding that it would be reimbursed for all these monies at the end of 2001 consistent with Ms. McMahon's representations, Aetna was allowed to draft the petitioner's account during 2001 in the amount of $271,628.38 for 2000 claims submitted during the three-month run-out period, some of which were paid by Aetna during the run-out period and some of which were paid by Aetna after the three-month run-out period had expired. For example, one claim drafted by Aetna from the petitioner's account on August 3, 2001, for $162,347.49 was based on costs incurred by BOL employee Roberta Swanson who died on January 6, 2001. Her costs were submitted to Aetna for payment on January 20, 2001, well within the "run-out" period. Yet Aetna *delayed* drafting BOL's account for this $162,347.49 until August 3, 2001.

At the end of the calendar year 2001, the petitioner requested Aetna to reimburse it for all the

claims paid as required by the stop-loss insurance extension coverage or "tail," as represented in McMahon's letter of December 28, 2000, i.e., in the total amount of $271,628.38. Aetna refused to reimburse the petitioner this sum of $271,628.38 contending in part that this "tail" coverage extended only to claims actually paid during the three-month "run-out" period ending March 31, 2001, and that most of the claims comprising this sum of $271,628.38, including $162,347.49 for Ms. Swanson, were *not* paid during this run-out period.

In the wake of Aetna's refusal to live up to its obligations under its stop-loss insurance extension agreement to reimburse fully BOL for the $271,628.38 in claims paid, the petitioner brought this civil action based on diversity of citizenship in the federal district court for the Eastern District of Louisiana against Aetna seeking $271,628.38, interest from January 1, 2000, "and for all general and equitable relief." Besides relying upon the facts described herein, BOL alleged that all of the claims for benefits for which Aetna drafted its account in 2001 were submitted by the health care providers in time to have been paid by Aetna during the three-month run-out period; and that to the extent that the condition of payment during the run-out period was not fulfilled, *Aetna caused the nonfulfillment by unduly delaying the payment of claims.*

BOL's complaint contained four separate counts and four separate theories of recovery under state law. The first count sought the recovery of damages in the amount of $271,628.38 and alleged that Aetna had misrepresented the scope of coverage under the stop-

loss insurance extension or "tail" which it purchased from Aetna for $36,132.78. The second count claimed it was entitled to damages because it detrimentally relied on Aetna's representations about the benefits and rights under the existing stop-loss insurance policy as well as the fully-insured coverage which it purchased from Aetna on January 1, 2001.

A third count sought damages for Aetna's breach of contract when it failed to reimburse the petitioner for all claims which were paid or which should have been paid during the three-month "run-out" period, all as required by McMahon's letter of December 28, 2000. Finally, BOL claimed in a fourth count that it was entitled to recover $271,628.38 in damages because Aetna breached its fiduciary duties in administering BOL's employee benefit plan when it "delay[ed] the processing of claims in a manner which would take the claim outside of the run-off period."

Following Aetna's answer and discovery, BOL moved for summary judgment contending that as a matter of law Aetna was liable under state law principles of breach of contract, misrepresentation and estoppel for refusing to perform under the stop-loss extension insurance agreement which BOL purchased for $36,132.78 and for refusing to reimburse BOL $271,628.38 at the end of 2001 for claims submitted during the three-month run-out period arising from medical services and costs incurred by BOL's employees during 2000. Aetna argued that all of BOL's state law claims for relief were preempted by the Employee Retirement Income Security Act, 29 U.S.C. Section 1001 *et seq.* ("ERISA").

On July 9, 2003, the federal district court, Berrigan, J., issued an order dismissing all of the petitioner's claims against Aetna as preempted by ERISA(App. 22-29). Mistakenly treating this fully *self-funded* employee benefit plan of BOL as a fully insured employee benefit plan under ERISA and then characterizing the stop-loss insurance coverage which BOL purchased from Aetna as itself a covered "plan" within ERISA, she concluded that all of BOL's state law claims "relate to" a covered employee benefit plan for purposes of ERISA's general preemption clause contained in 29 U.S.C. Section 1144 (Section 514 of ERISA)(App. 24-25).

The district judge erroneously found that all of BOL's claims address an area of exclusive federal concern and directly affect the relationship between traditional ERISA entities, i.e., the employer, the plan and its fiduciaries:

> The parties are two traditional ERISA entities: the employer and the plan provider. The claims all pertain to the terms of the ERISA-governed plan and will require the examination of plan terms. Such plan interpretation has been found to be sufficient to warrant ERISA preemption.

(App. 24)(citations omitted). Additionally, the district court did not believe that BOL's new claim under La. Rev. St. Section 22:657 (penalizing an insurer by doubling the amount of benefits due and awarding attorney's fees for its unreasonable delay in paying a claim), could avoid preemption since it creates an alternative remedy that is not authorized under ERISA's civil enforcement scheme(App. 25-27).

The district judge dismissed BOL's state law claims for misrepresentation, detrimental reliance and violation of La. Rev. St. Section 22:657, as preempted by ERISA(App. 27). BOL's other claims for breach of contract, violations of La. Rev. St. Section 22:658, and breach of fiduciary duty were dismissed as abandoned(App. 27). These rulings were postponed for ten days in order to allow BOL to amend its complaint(App. 27-28). BOL did so on July 22, 2003, adding claims against Aetna for breach of ERISA fiduciary duty and seeking in a separate count "equitable relief under ERISA" pursuant to 29 U.S. C. Sections 1109 and 1132(a)(3).

On September 8, 2004, the same district judge denied BOL's motion for declaratory relief and granted Aetna's motion for summary judgment on BOL's new claims(App. 16-21). Reaffirming its earlier dismissal of all of the petitioner's state law claims because of ERISA preemption, the district court noted BOL's acknowledgment that it was seeking *legal* relief in this suit, i.e., the award of compensatory damages against Aetna for breaching its contractual obligation to pay money(App. 18;19). However, the district judge ruled that since Section 502 of ERISA (29 U.S.C. Section 1132(a)(3)) provides only equitable—*not* legal—relief, the petitioner's claims must be dismissed (App. 18-20).

BOL appealed both of these decisions by Judge Berrigan. On August 4, 2006, the court of appeals for the Fifth Circuit reversed the district judge's summary dismissal of BOL's state law claims for misrepresentation, detrimental reliance and breach of contract and remanded the matter to the district court for further proceedings. In so ruling, the court of

appeals found that BOL had abandoned any claim that Aetna had breached its fiduciary duty as plan administrator in delaying the payment of health care benefits, a waiver which also caused its claim for attorney's fees under La. Rev. St. Section 22:657 to fail(App. 4;11-12).

The gist of its ruling was that BOL's proof in support of its state law claims will not invade ERISA's exclusive area of federal concern since BOL can recover on these claims by showing simply that Aetna drafted its account during the three-month stop-loss extension period rather than by showing that Aetna delayed processing these claims as a plan administrator, this latter evidentiary showing too invasive of the ERISA relationship to avoid preemption(App. 6-7).

Moreover, the court of appeals determined that Aetna was acting as a vendor of insurance--- *not* as an ERISA plan fiduciary----when it negotiated with BOL over which claims would be covered by the stop-loss insurance extension(App. 8). In addition,

> [t]he duties that Aetna has allegedly breached in negotiating the stop-loss policy were owed to the Bank, the benefits of stop-loss insurance inure solely to the Bank, and Aetna cites no evidence that the stop-loss policy is a plan asset or was purchased with plan assets.

(App. 8). Finally, the court concluded that an insurance company selling stop-loss insurance for an ERISA plan is not necessarily a plan fiduciary and should not be regulated by ERISA(App. 8-9).

Aetna sought rehearing. On October 18, 2006, the court filed a substitute opinion(App.30-44). It ruled that even though Aetna was providing stop-loss *insurance* to BOL—not a traditional ERISA-type employee benefit, to the extent that BOL had to prove for its breach of contract claim that Aetna in violation of its duty under the stop-loss extension agreement had improperly delayed processing and paying benefit claims under this self funded plan, it was inquiring into an area of exclusive federal concern and was therefore preempted by ERISA (App.35-36). Moreover, it ruled that the only claim of BOL which implicates Aetna's role as an ERISA fiduciary is this one for breach of contract seeking reimbursement for those benefit claims which Aetna delayed processing and paying during the three-month "run-out" period(App. 37-38).

Because Aetna had established an ERISA preemption defense for this breach of contract claim, the panel remanded the case to the district court for trial on BOL's claims of detrimental reliance, misrepresentation and its breach of contract claim based upon Aetna's failure to reimburse BOL for benefit claims which were actually paid during the three-month "run-out" period(App. 38-39).

BOL has now brought to this Court its petition seeking a writ of certiorari to the United States Court of Appeals for the Fifth Circuit.

## REASONS FOR GRANTING THE PETITION

**1. There Is A Split of Opinion Among the Federal Courts About Whether State Law Claims Seeking To Enforce A Stop-Loss Insurance Agreement For A Self Funded Employee Benefit Plan Are Preempted Under ERISA And This Court Should Resolve The Controversy, Find No Preemption Under ERISA And Thereby Provide Small and Medium-Size Businesses Like The Petitioner With The Actual Insurance Protection Against Catastrophic Losses They Purchased For Their Self Funded Plans.**

When Congress enacted ERISA in 1974, it decided to insure uniformity in employee benefit plan regulation and avoid conflicting and overlapping State regulation by providing in 29 U.S.C. Section 1144(a), that "the provisions of this subchapter and subchapter III of this chapter shall supercede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan...."(emphasis supplied). This language has been broadly interpreted by this Court to displace any State law or State common law causes of action which "relate[] to" a benefit plan within ERISA's ambit. *FMC Corp. Holliday*, 498 U.S. 52, 58(1990). *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 98(1983).

While ERISA's preemptive sweep is expansive, the Savings Clause contained in 29 U.S.C. Section 1144(b)(2)(A)("...nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance...."), is stated almost as broadly. Yet this Court has construed this language to apply only to state laws regulating *core*

insurance issues, i.e., only those state laws which involve contractual arrangements for protecting against financial loss through spreading a policyholder's risk, affect an integral part of the policy relationship or address only entities within the insurance industry itself. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739-743(1985). Thus only a claim based on state law regulating the core business of insurance as defined in *Metropolitan's* three-part test is "saved" from preemption by virtue of the Savings Clause of Section 1144(b)(2)(A), even if it "relates to" an employee benefit plan within the meaning of Section 1144(a).

ERISA further contains a so-called "Deemer" Clause which limits the reach of the Savings Clause. 29 U.S.C. Section 1144(b)(2)(B) provides that an employee benefit plan "shall [not] be deemed to be an insurance company or other insurer...or to be engaged in the business of insurance ...for purposes of any law or any State purporting to regulate insurance companies [or] insurance contracts...." In *FMC Corp. Holliday*, 498 U.S. at 61, the Court held that a self funded employee benefit plan is exempt from state laws which regulate insurance by virtue of the "deemer clause" but a fully insured plan remains somewhat regulated by the State in that the insurance company which insures the plan is subject to State insurance regulation. *Id.* In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48(1987), this Court ruled that the processing of benefit claims was not the kind of core insurance activity which would be saved from preemption by the Savings Clause. *Id.* at 57.

This law favoring broad ERISA preemption has consistently thwarted State attempts to regulate or

reform welfare benefit plans; and because ERISA itself brings little substantive regulation to bear upon such plans, it has "left a sizable regulatory void within which employers are virtually free to create and administer their welfare plans as they see fit." T. Paredes, *Stop-loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 Harv. Jour. of Leg.233, 239(1997). Coupled with the emergent trend of more and more small to mid-size businesses choosing to self fund their employee benefit plans and then buy stop-loss insurance to minimize any catastrophic losses, the regulatory vacuum attendant to these plans is of growing concern to State regulators, plan sponsors and the public in general.

The present controversy typifies the problem of no oversight and no legal consequences for stop-loss insurance providers of self funded benefit plans. The petitioner paid Aetna $36,132.78 to purchase a "tail" to its stop-loss policy for its fully self funded plan and thereby obligated Aetna to pay "run-out" claims under the 2000 plan for three months after the 2000 stop-loss insurance expired on December 31, 2000. Instead of drafting BOL's account within the "run out" period for the claims, as it should have, Aetna delayed for months and then claimed that no reimbursement to BOL was due since the claims were not paid during the "run-out" period. The decision below determines that BOL's state law breach of contract claim against Aetna is preempted to the extent that it relies on Aetna's *delay* in processing these claims, the very heart of Aetna's bad faith breaching conduct, because such proof would touch on a traditional ERISA activity, the payment of claims by the plan administrator.

Yet this is a fully self funded plan by BOL; Aetna's administration of the plan is by contract with BOL, *not* because Aetna is the plan sponsor. Moreover, the stop-loss insurance arrangement, exemplified by Ms. McMahon's letter, is purely contractual. Neither the "tail" extension of the stop-loss coverage nor the promise to reimburse by Aetna has anything to do with processing claims of beneficiaries to the plan, the fiduciary duties of administrators to beneficiaries or the plan's language, terms or benefits. There were no breaches of fiduciary duty here, just breaches of contract by Aetna. BOL's proof of Aetna's breach of contract under state law should be unimpeded by ERISA preemption and the lower court was wrong to rule otherwise.

This Court has yet to rule on what effect the purchase of stop-loss insurance has on the status of a fully self funded employee welfare plan. In the absence of any definitive ruling by this Court, the lower federal courts have come to divergent opinions about whether state law claims seeking to enforce a stop-loss insurance agreement for a self funded employee benefit plan are preempted under ERISA.

Some courts conclude that state law claims against the stop-loss insurance carrier for breach of the insurer's duties under the stop-loss agreement do not implicate any regulation of the ERISA plan, do not involve a plan fiduciary, would leave the employer without a remedy against an entity with no authority to approve or deny employee claims for benefits and therefore are not preempted by ERISA. *Geweke Ford v. St. Joseph's Omni Pref. Care, Inc.*, 130 F.3d 1355, 1359-1360(9th Cir. 1997). *Northern Group Servs., Inc. v.*

*Automobile Owners Ins. Co.*, 833 F.2d 85, 91(6th Cir. 1987). *Seneca Beverage Corp. v. Healthnow of New York*, 383 F. Supp.2d 413, 423(W.D.N.Y.2005). *Northern Kare Facilities v. Benefirst, LLC*, 344 F. Supp. 2d 283, 286-289(D. Mass. 2004). *Workforce Development v. Corporate Ben. Services*, 316 F. Supp.2d 854, 858(D. Minn. 2004). *Computer Aided Design Systems v. Safeco Life Ins.*, 235 F. Supp. 2d 1052, 1057(S.D. Iowa 2002).*Strategic Outsourcing, Inc. v. Commerce Benefits Group Agency, Inc.*, 54 F. Supp. 2d 566, 573(W.D.N.C. 1999). *Union Health Care, Inc. v. John Alden Life Ins. Co.*, 908 F. Supp. 429, 431(S.D. Miss. 1995).

Besides the Fifth Circuit Court of Appeals in this case, other federal courts have held that the purchase of stop-loss insurance does *not* convert a fully self funded employee benefit plan into an "insured" one which would avoid ERISA preemption and therefore all state law claims attending performance of the stop-loss agreement are preempted under ERISA. *Bill Gray Enterprises, Inc. Emp. H. & W. v. Gourley*, 248 F.3d 206, 213-214(3rd Cir.2001). *Tri-State Mach., Inc. v. Nationwide Life Ins. Co.*, 33 F.3d 309, 315(4th Cir. 1994). *Thompson v. Talquin Bldg. Products Co.*, 928 F.2d 649, 653(4th Cir. 1991).

In order to remedy this confusion among the federal courts about whether claims such as those BOL has made against Aetna here for breach of contract are preempted, this Court should grant the petition and harmonize these disparate decisions, especially given the increasing number of small to mid-size businesses which have chosen to self fund their employee welfare plan and then purchase stop-loss insurance coverage in order to avoid catastrophic losses. A decision rejecting

preemption should ensue given the basic principles of insurance and contract law, the substance and function of stop-loss insurance and the fact that employers like BOL who purchase such insurance deserve meaningful remedies under state law when the insurer fails to live up its promises.

**2. This Court Should Construe ERISA's Remedies To Include The Award Of Compensatory Damages As Restitution For An Employer When Its Stop-Loss Insurer Fails To Live Up To Its Promises Contained In The Stop-Loss Insurance Agreement.**

In *Great West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 210-215(2002), and *Mertens v. Hewitt Associates*, 508 U.S. 248, 360-261(1993), this Court decided that the "equitable" remedies expressly provided an ERISA participant or beneficiary does *not* include the payment of money as restitution. *Id.*

This cramped construction of the relief due complainants under ERISA has produced perverse results. As Circuit Judge Becker wrote in his concurring opinion in *DiFelice v. Aetna US Healthcare*, 346 F. 3d 442, 459(3rd Cir. 2003), the unavailability of extra-contractual damages renders contingency fees entirely impractical, discouraging legal help when it is most needed; makes it inordinately difficult to secure injunctive relief while encouraging benefit plans to deny claims in bad faith; and gives some benefit plans including HMOs "every incentive to act in their own and not in their beneficiaries' best interest while simultaneously making it incredibly difficult for plan participants to pursue what meager remedies they possess...." *Id. See Cicio v. Does*, 321 F. 3d 83, 106-

110(2d Cir. 2003(Calabresi, J., dissenting in part)(lack of damage award under ERISA leads to unprincipled analysis in order to provide relief). In effect, the Court's construction of ERISA has prevented the very purposes which ERISA was enacted to promote, i.e., the safety, predictability and security of employer benefit plans.

In a dissenting opinion in *Great West Life*, 534 U.S. at 224-234, and a concurring opinion in *Aetna Health Inc. v. Davila*, 542 U.S. 200, 222-224(2004, Justice Ginsburg has suggested that Congress intended that ERISA replicate the core principles of trust remedy law, including the make-whole standard of trust restitution which includes money damages. *Id.* In addition, Justice Scalia, concurring with Justice Ginsburg in *California Div. of Labor Stand. Enf. v. Dillingham Construction, N.A., Inc.*, 519 U.S. 316 (1997), has indicated a willingness to reassess anew the entire issue of ERISA preemption.

The gaps in ERISA's statutory law are apparent and it is now appropriate for this Court to develop new federal common law in order to allow for an award of compensatory damages to an employer when its stop-loss insurance carrier through malfeasance, negligence or deliberate choice breaches the stop-loss insurance agreement to reimburse the employer for the employee benefit claims it paid during the stop-loss period. See, e.g., *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110(1989); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. at 56.

## CONCLUSION

For all of the reasons identified herein, a writ of certiorari should issue to the United States Court of Appeals for the Fifth Circuit in order to review its decision and, ultimately, to determine that the resort to stop-loss insurance for self funded employee benefit plans does not invoke ERISA preemption and that even if ERISA relationships are implicated, state law claims arising from the insurer's breach of the stop-loss insurance contract invoke legal remedies including the award of compensatory damages; or to declare that the district court possesses the jurisdiction to determine all of the petitioner's claims under state law as stated in its original complaint; or to provide BOL with such other relief as is fair and just in the circumstances.

Respectfully submitted,

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(any footnotes trail end of each document)

No. 04-30986

UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BANK OF LOUISIANA,

Plaintiff-Appellant,

versus

AETNA US HEALTHCARE INC; AETNA LIFE INSURANCE COMPANY,

Defendants-Appellees.

August 4, 2006, Filed

COUNSEL: For BANK OF LOUISIANA, Plaintiff - Appellant: Henry L. Klein, New Orleans, LA.

For AETNA US HEALTHCARE INC, Defendant - Appellee: Richard Guy Duplantier, Jr., Galloway, Johnson, Tompkins, Burr & Smith, New Orleans, LA.

For AETNA US HEALTHCARE INC, Defendant - Appellee: John Bruce Shely, Kendall Matthew Gray, Andrews & Kurth, Houston, TX.

For AETNA LIFE INSURANCE CO., Defendant - Appellee:Richard Guy Duplantier, Jr., Galloway, Johnson, Tompkins, Burr & Smith, New Orleans, LA.

For AETNA LIFE INSURANCE CO., Defendant - Appellee:John Bruce Shely, Kendall Matthew Gray, Andrews & Kurth, Houston, TX.

JUDGES: Before REAVLEY, GARZA, and BENAVIDES, Circuit Judges. REAVLEY, Circuit Judge, specially concurring.

OPINION BY: EMILIO M. GARZA

OPINION: EMILIO M. GARZA, Circuit Judge:

The Bank of Louisiana ("the Bank") appeals a summary judgment for the defendants Aetna US Healthcare and Aetna Life Insurance (collectively "Aetna"). The issue on appeal is whether the Bank's state law claims of detrimental reliance, breach of contract, and misrepresentation are preempted by the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq. ("ERISA").

I

In 1995, the Bank contracted to have Aetna administer and provide stop-loss insurance for its self-insured employee benefit plan ("the Plan").[1] The stop-loss policy provided an "individual" or "specific stop-loss amount" of $ 50,000 and an "aggregate stop-loss amount" of $ 600,000.[2] The stop-loss coverage was scheduled to terminate on December 31, 2000.

The Bank, however, reached the aggregate stop-loss amount in 2000. Late in that year, the parties met to form a new contract that would provide fully-insured coverage commencing on January 1, 2001. The Bank

also purchased an extension on its stop-loss coverage that would apply to claims incurred in 2000 and for which benefits would be paid during the first three months of 2001. In a letter from account representative Stacy McMahon, Aetna stated that the stop-loss extension would mean that the Bank would "have no additional claim liabilities for 2000 and no additional fund transfers will be requested." McMahon further stated that Aetna would "start wiring [the Bank's] account for claims paid during the runoff period and [the Bank would] be reimbursed at year-end." During the three month run-off period, the Bank submitted $ 271,628.38 in net claims incurred by plan members in 2000. (R. 177, 181, 218, 243.) Aetna drafted the Bank's account for these claims over the course of 2001 and 2002. Five of these drafts occurred during the three-month stop-loss extension period, totaling $ 102,720.06. Nevertheless, Aetna declined to reimburse the Bank.

The Bank filed a complaint alleging that Aetna had negligently or fraudulently "misrepresented the value and benefit of its payment" to Aetna for the stop-loss policy. In particular, the Bank first claimed that Aetna misrepresented that, pursuant to the stop-loss policy, Aetna would reimburse the Bank for the $ 271,628.38 that it drafted from the Bank's account. Second, the Bank alleged that Aetna had falsely represented that Aetna would reimburse the Bank for the $ 271,628.38 in charges and that the Bank had detrimentally relied on this representation. Third, the Bank alleged that Aetna had breached a contract to reimburse it for the $ 271,628.38 of account drafts. Fourth, the Bank alleged that Aetna had breached its fiduciary duties as plan administrator by delaying the processing of claims to remove them from the stop-loss coverage. Finally, in an

amended complaint, the Bank alleged that Aetna had violated Louisiana Revised Statutes 22:658[3] and 22:1220.[4]

Aetna moved for summary judgment on the ground that the Bank's claims were preempted by ERISA. In a series of briefs, Aetna argued that ERISA preempted claims between an employer and a plan administrator. (R. 930.) The Bank responded that its claim of detrimental reliance and a claim for attorney's fees under Louisiana Revised Statute 22:657, the latter of which it had not pled,[5] were not preempted because they exclusively involved parties providing services to an ERISA plan in a non-fiduciary capacity. (R. 635, 882.) The Bank withdrew its breach of fiduciary duty claim[6] and abandoned its claims under Louisiana Revised Statute 22:658 & 22:1220. The district court held that ERISA preempted all of the Bank's remaining claims and granted summary judgment for Aetna.

II

In reviewing a summary judgment, we apply the same standard as the district court. *Martin v. Alamo Community Coll. Dist.*, 353 F.3d 409, 412 (5th Cir. 2003). We affirm only if there is no genuine issue of material fact and the movant is entitled to judgment as a matter of law. *Id.* For a defendant to obtain summary judgment on an affirmative defense, it must establish beyond dispute all of the defense's essential elements. *Id.* We review the district court's legal determination that ERISA preempts a state law claim *de novo*. *Bullock v. Equitable Life Assurance Soc'y of the United States*, 259 F.3d 395, 399 (5th Cir. 2001).

A

ERISA's preemption clause, 29 U.S.C. § 1144(a), states that with certain exceptions, ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." The Supreme Court has "observed repeatedly that this broadly worded provision is 'clearly expansive.' " *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 146, 121 S. Ct. 1322, 149 L. Ed. 2d 264 (2001) (quoting *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995)). The Court has held that a state law "relates to an ERISA plan 'if it has a connection with or reference to such a plan.' " *Id.* at 147 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97, 103 S. Ct. 2890, 77 L. Ed. 2d 490 (1983)). Simultaneously, however, the Court recognizes that, given its broadest reading, the phrase "relate to" would encompass virtually all state law, and that its "connection with" and "reference to" interpretations are "scarcely more restrictive." *Id.* at 146-47. The Court has, therefore, declined to apply an "uncritical literalism" to the phrase and instead takes the "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." *Id.* at 147 (internal quotation marks omitted).

Congress's objectives in enacting ERISA were to

protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other

information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing appropriate remedies, sanctions, and ready access to the Federal courts.

29 U.S.C. § 1001(b). To this end, ERISA's preemption provision is intended "to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Egelhoff*, 532 U.S. at 148 (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9, 107 S. Ct. 2211, 96 L. Ed. 2d 1 (1987)). A uniform administrative scheme serves to minimize administrative and financial burdens by avoiding the need to tailor plans to the peculiarities of the law of each state. *Ingersoll-Rand Co. v. McClendon*, 498 U.S 133, 142, 111 S. Ct. 478, 112 L. Ed. 2d 474 (1990).

In light of these statutory objectives, this court applies a two-prong test to the defense of ERISA preemption. A defendant pleading preemption must prove that: (1) the claim "addresses an area of exclusive federal concern, such as the right to receive benefits under the terms of the Plan; and (2) the claim directly affects the relationship among traditional ERISA entities--the employer, the plan and its fiduciaries, and the participants and beneficiaries." *Mayeaux v. La. Health Serv. and Indem. Co.*, 376 F.3d 420, 432 (5th Cir. 2004). Because ERISA preemption is an affirmative defense, Aetna bears the burden of proof on both elements. *See Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63, 107 S. Ct. 1542, 95 L. Ed. 2d 55 (1987) (ERISA preemption is a defense); *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505, 508 (10th Cir. 1991) (defendant bears burden of proving

ERISA preemption); *Kanne v. Conn. Gen. Life Ins. Co.*, 867 F.2d 489, 492 n.4 (9th Cir. 1988) (same).

Aetna argues that the Bank's claims require inquiry into the administration of the Plan--an area of exclusive federal concern--because some of the drafts on the Bank's account were for benefit claims paid after the stop-loss extension expired. Aetna contends that the Bank intends to prove that these drafts nonetheless fall within the stop-loss extension because they arise from benefit claims that Aetna improperly delayed processing. To the extent that the Bank intends to prove its claims through evidence that Aetna improperly administered the Plan, Aetna is correct that they would require inquiry into an area of exclusive federal concern. *See Hollis v. Provident Life and Accident Ins. Co.*, 259 F.3d 410, 414 (5th Cir. 2001) (right to receive benefits under an ERISA plan is an area of exclusive federal concern); *Hubbard v. Blue Cross & Blue Shield Ass'n*, 42 F.3d 942, 946 (5th Cir. 1995) (claim that would require inquiry into how benefit claims were processed implicates area of federal concern). There is, however, evidence that Aetna drafted the Bank's account multiple times during the stop-loss extension. Because those drafts occurred during the stop-loss extension, the Bank need not prove that Aetna improperly delayed processing these claims to recover. Accordingly, Aetna has established the first element of the defense of preemption as a matter of law only to the extent that the Bank's intends to rely upon evidence that Aetna delayed processing claims for benefits.[7]

Aetna argues that the second element of its defense is satisfied as a matter of law because the parties are two

traditional ERISA entities--an employer and a plan administrator. The Bank contends, however, that Aetna was acting in its capacity as a vendor of insurance, not as a fiduciary of the Plan. For purposes of ERISA preemption the critical distinction is not whether the parties to a claim are traditional ERISA entities in some capacity, but instead whether the relevant state law affects an aspect of the relationship that is comprehensively regulated by ERISA. As we have noted, ERISA may preempt some claims between traditional ERISA entities but not others.[8] And a party may qualify as an ERISA fiduciary with regard to some claims but not others. *See Pegram v. Herdrich*, 530 U.S. 211, 225-26, 120 S. Ct. 2143, 147 L. Ed. 2d 164 (2000) (ERISA defines party as fiduciary "only 'to the extent' that he acts in such a capacity in relation to a plan") (quoting 29 U.S.C. § 1002(21)(A)). "[T]he critical determination [is] whether the claim itself created a relationship between the plaintiff and defendant that is so intertwined with an ERISA plan that it cannot be separated." *Hobson*, 75 Fed.Appx. at 954.

Aetna argues that it is an ERISA fiduciary because the Bank has delegated to it the discretionary responsibility to administer the Plan.[9] The Bank correctly contends, however, that Aetna was not acting in a fiduciary capacity when it represented to the Bank which claims would be covered by the stop-loss insurance policy extension. The duties that Aetna has allegedly breached in negotiating the stop-loss policy were owed to the Bank, the benefits of stop-loss insurance inure solely to the Bank, and Aetna cites no evidence that the stop-loss policy is a plan asset or was purchased with plan assets. *Cf.* DEPARTMENT OF LABOR ADVISORY OPINION 92-02A, available at

1992 ERISA LEXIS 5, 1992 WL 15175 (stop-loss policy is not a plan asset). *But cf. Patelco Credit Union v. Sahni*, 262 F.3d 897, 908 (9th Cir. 2001) (checks for stop-loss benefits are plan assets).

Aetna identifies no cases holding that a stop-loss insurer is necessarily a plan fiduciary. The majority of cases are to the contrary. For example, the Ninth Circuit held in *Geweke Ford v. St. Joseph's Omni Preferred Care Inc.*, 130 F.3d 1355 (9th Cir. 1997), that a plan's relationship to its stop-loss insurer is like that between any commercial entities and is not regulated by ERISA.[10] The reasoning of these courts is persuasive and consistent with our own. The Bank's claims implicate Aetna's responsibilities with respect to Plan administration only to the extent they challenge Aetna's processing of benefit claims.[11]

III

For the foregoing reasons, we reverse the district court's grant of summary judgment on the Bank's claims of detrimental reliance, breach of contract, and misrepresentation; affirm the grant of summary judgment on the Bank's Louisiana Revised Statute 22:657 claim; and remand for proceedings not inconsistent with this opinion.

AFFIRMED IN PART, REVERSED IN PART, AND REMANDED.

CONCUR BY: REAVLEY

CONCUR: REAVLEY, Circuit Judge, specially concurring:

I concur in the judgment because this appeal is by the Bank against Aetna US Healthcare Inc., the issuer of the stop-loss policy. That party is separate from Aetna Life Insurance Co., the plan administrator with fiduciary responsibility.

Footnotes

n1 The parties do not dispute that this qualifies as an ERISA plan. *See* 29 U.S.C. § 1002(1) (defining employee welfare benefit plans subject to ERISA).

n2 The distinction between an individual or specific stop-loss amount and the aggregate stop-loss amount is described in Troy Paredes, Note, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 HARV. J. LEGIS. 233, 249 (1997), as follows:

There are two types of stop-loss insurance. Specific stop-loss insurance covers a plan against the risk that a particular participant's claims will exceed some specified level. For example, if the insurance kicks in when an individual's claims exceed $ 20,000 per year and a participant has bona fide claims of $ 30,000, the plan's stop-loss insurer covers $ 10,000 of the person's claims. Alternatively, aggregate stop-loss insurance covers a plan against the risk that the sum of all of its participants' claims will exceed some specified level. For example, if the insurance kicks in when aggregate claims exceed $ 2 million per year and claims under the plan total $ 2.5 million, the stop-loss insurer covers $ 500,000 of the claims.

*See also* Dennis K. Schaeffer, Comment, *Insuring the*

*Protection of ERISA Plan Participants: ERISA Preemption and the Government's Duty to Regulate Self-Insured Health Plans*, 47 BUFF. L. REV. 1085, 1108-09 (1999) (discussing difference).

n3 Louisiana Revised Statute 22:658 requires insurers issuing certain types of policies to pay the amount of claims due within thirty days of proof of the loss.

n4 Louisiana Revised Statute 22:1220 imposes upon insurers a duty of good faith and fair dealing.

n5 Louisiana Revised Statute 22:657 provides that claim arising under the terms of health and accident contracts must be paid within thirty days of the date that the insurer receives written notice and proof of the claim. Failure to comply renders the insurer liable for penalties and attorney's fees. Aetna does not argue that the Bank's failure to properly plead this claim warrants affirmance.

n6 *See* District Court's Order and Reasons at 2 n.1 (July 9, 2003) (noting that the Bank had "indicated its intention to withdraw the breach of fiduciary duty claim"); Bank of Louisiana's Memorandum Regarding ERISA Preemption at 3 n.2 (Apr. 23, 2003) ("[W]e concede that BOL's Count Four, claiming breach of fiduciary duty, may be preempted by ERISA. Because the Count adds nothing to the gravamen of BOL's complaint, we will withdraw that Count without prejudice.").

Because the Bank has withdrawn its claim that Aetna delayed paying health care benefits, and a default to perform the stop-loss policy is not covered by the

statute, the Bank's claim for attorney's fees under Louisiana Revised Statute 22:657 fails.

n7 Although the district court concluded that the claims implicate an area of exclusive federal concern because they "all pertain to the terms of an ERISA-governed plan and will require the examination of the plan terms," there is nothing in the summary judgment record to support that conclusion. Neither Aetna nor the district court identified what portion of the agreement between the parties is in dispute. *Cf. Perkins v. Time Ins. Co.*, 898 F.2d 470, 473 (5th Cir. 1990) (claim for fraud and misrepresentation in the procurement of an ERISA plan are not preempted).

n8 *See Hobson v. Robinson*, 75 Fed.Appx. 949, 955 (5th Cir. 2003) (unpublished) (party may be a fiduciary with regard to some claims but not others); *Smith v. Tex. Children's Hosp.*, 84 F.3d 152 (5th Cir. 1996) (fraudulent inducement claim against employer not preempted while breach of contract claim was preempted); *Hook v. Morrison Milling Co.*, 38 F.3d 776, 783 (5th Cir. 1994) (ERISA does not preempt all state law claims between an employee and an employer, merely because the employer administers an ERISA plan to which the employee belongs); *Sommers Drug Stores Co. v. Employee Profit Sharing Trust*, 793 F.2d 1456 (5th Cir. 1986) (claim for common law breach of corporate fiduciary duty was not preempted by ERISA, even though the defendant/corporate director was an ERISA plan fiduciary and the plaintiffs/employees were plan beneficiaries).

n9 A party acts in a fiduciary capacity when he: 1) exercises discretionary control over plan assets; 2) he

renders investment advice for a fee to the plan; or 3) he has discretionary responsibility with regard to plan administration. 29 U.S.C. § 1002(21)(A); *see also Tri-State Mach., Inc. v. Nationwide Life Ins. Co.*, 33 F.3d 309, 313-14 (4th Cir. 1994) (claims by employer against plan administrator and stop-loss insurer for delaying the processing of claims are preempted); *Iron Workers Mid-South Pension Fund v. Terotechnology Corp.*, 891 F.2d 548, 553 (5th Cir. 1990) ("the state law is preempted by section 514(a) if the conduct sought to be regulated by the state law is 'part of the administration of an employee benefit plan' " (quoting *Martori Bros. Distrib. v. James-Massengale*, 781 F.2d 1349, 1358 (9th Cir. 1986))).

n10 *See also Seneca Beverage Corp. v. HealthNow N.Y., Inc.*, 383 F. Supp. 2d 413, 423 (W.D.N.Y. 2005) (stop-loss insurer is not a fiduciary); *Northern Kare Facilities/Kingdom Kare, LLC v. Benefirst LLC*, 344 F. Supp. 2d 283, 287 (D.Mass. 2004) (same); *Deeter v. Greene, Tween and Co., Inc.*, CIV. A. 98-1222, 1998 U.S. Dist. LEXIS 14625, 1998 WL 639190 (E.D. Pa. Sept. 18, 1998) (same); *Union Health Care, Inc. v. John Alden Life Ins. Co.*, 908 F. Supp. 429, 432-36 (S.D. Miss. 1995) (same).

n11 Aetna relies on *Tri-State Machine, Inc. v. Nationwide Life Insurance Co.*, 33 F.3d 309 (4th Cir. 1994), but that case is not to the contrary. Tri-State Machine, an employer, sued Nationwide Life Insurance, the administrator and stop-loss insurer for its ERISA plan. Tri-State alleged that Nationwide Life "delayed processing claims in years when the stop-loss limit had been reached in order to deflect them into a new policy year to be charged against Tri-State under its self-

funding obligations." *Id.* at 314. The Fourth Circuit held that such an allegation was essentially a challenge to a plan administrator's processing of claims and therefore related to the plan. *Id.* In the present case, however, the Bank has abandoned its claim that Aetna breached its fiduciary duties by delaying the processing of claims. The wrong the Bank seeks to recover for in the remaining claims is Aetna's failure to reimburse it as it represented that it would pursuant to the stop-loss policy. Such a claim does not concern the processing of claims for benefits.

The Fourth Circuit's cases are consistent with our reasoning that the parties are not fiduciaries with respect to the Bank's claims. In *Phelps v. C.T. Enterprises, Inc.*, 394 F.3d 213, 219 (4th Cir. 2005), the court "emphasized that fiduciary duty under ERISA is not an all-or-nothing concept." *See also Cotton v. Mass. Mutual Life Ins. Co.*, 402 F.3d 1267, 1277 (11th Cir. 2005) (fiduciary status under ERISA not an "all-or-nothing concept").

*Broadnax Mills, Inc. v. Blue Cross and Blue Shield of Virginia*, 867 F. Supp. 398 (E.D. Va. 1994), is also distinguishable. The employer in *Broadnax Mills* sued the plan administrator and stop-loss insurer on the ground that it negligently failed to advise it to obtain an aggregate stop-loss policy and breached the Plan's Administrative Service Agreement. In *Broadnax Mills*, it was conceded that the stop-loss insurance was purchased by funds contributed by plan participants and therefore concerned the disposal of plan assets. *See id.* at 403. Aetna points to no similar concession in this case. The plaintiff in *Broadnax Mills* also alleged that the plan administrator breached its duty to disclose and

report the financial status of the plan. *Id.* at 403-04. The Bank's claims do not involve similar allegations.

CIVIL ACTION NO. 02-236 SECTION "C" (5)
UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF LOUISIANA

BANK OF LOUISIANA

VERSUS

AETNA US HEALTHCARE, INC., ET AL

September 8, 2004, Decided
September 8, 2004, Filed, Entered

**COUNSEL:** For BANK OF LOUISIANA, plaintiff: Maria Nan Alessandra, Phelps Dunbar, LLP, Henry L. Klein, James Harold Daigle, Jr., Klein Daigle, LLC, New Orleans, LA.

For AETNA US HEALTHCARE, INC., AETNA LIFE INSURANCE COMPANY, defendants: Richard G. Duplantier, Jr., Stephen James Moore, Galloway, Johnson, Tompkins, Burr & Smith, John L. Fontenot, Jr., Adams & Reese, New Orleans, LA.

**JUDGES:** HELEN G. BERRIGAN, UNITED STATES DISTRICT JUDGE.

**OPINION BY:** HELEN G. BERRIGAN

**OPINION:**

ORDER AND REASONS

This matter comes before the Court on motion for partial summary judgment and alternatively, for declaratory relief filed by the plaintiff, Bank of

Louisiana ("BOL") and motion for summary judgment filed by Aetna US Healthcare, Inc. and Aetna Life Insurance Company (collectively "Aetna"). Having considered the record, the memoranda of counsel and the law, the Court has determined that the motion filed by BOL should be denied and the motion filed by the defendants should be granted for the following reasons.

The Court has previously dismissed all of the plaintiff's state law claims under the Employee Retirement Income Security Act, *29 U.S.C. § 1001 et seq.* (Rec. Doc. 74). The Court afforded the plaintiff an opportunity to amend its complaint, which it did with a second[1] Second Amended Complaint setting forth additional claims of "ERISA Fiduciary Breach" and "Equitable Relief." (Rec. Doc. 76).[2]

BOL does not present any new argument in its motion arguing against ERISA preemption, and essentially argues that ERISA is irrelevant because the Aetna policies were with BOL, not its employees.[3] The Court has carefully reconsidered the caselaw, and reaffirms its previous holding that the state law claims made by BOL are preempted. It also agrees that ERISA creates substantial hurdles for a plaintiff in a case such as this. "Stop-loss insurance, by which an employer that self-funds its benefit plan insures against the risk of excessive payouts, does not fit neatly into ERISA's regulatory framework." Troy Paredes, Note, Stop-Loss Insurance, State Regulation, and ERISA: Defining *the Scope of Federal Preemption, 34 Harv. J. On Legis. 233 (1997).* See e.g. *Sealy, Inc. v. Nationwide Mutual Insurance Co., 286 F. Supp.2d 625 (M.D.N.C. 2003)*(employer with self-funded plan sought equitable restitution under ERISA against stop-loss insurance company).

Although it appears that the plaintiff does not oppose the defendants' motion for summary judgment as it pertains to the ERISA claims, the determinative factor in granting summary judgment in favor of the defendant is the plaintiff's candid admission that it is seeking legal relief.

Only equitable relief is available in an ERISA case to non-participants and non-beneficiaries under *29 U.S.C. § 1132(a). Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204, 151 L. Ed. 2d 635, 122 S. Ct. 708 (2002).*[4] To the extent that the plaintiff sues as a fiduciary or employer, monetary relief for the claimed contractual obligation is not equitable in nature.[5] *Bauhaus USA, Inc. v. Copeland, 292 F.3d 439 (5th Cir. 2002).* "An injunction to compel the payment of money past due under a contract, or specific performance of a past due monetary obligation, was not typically available in equity." *Great-West, 524 U.S. at 210-211*;

> The Court in *Great-West* characterized the suit in that case as "[a] claim for money due and owing under a contract" and that such a suit is "quintessentially an action at law." Because the facts in today's case are, in principle, indistinguishable from those in *Great-West*, we are bound by that decision and hold that *§ 502(a)(3)* does not authorize [plaintiff's] suit.

*Bauhaus, 292 F.3d at 445*, quoting *Great-West, 534 U.S. at 210.*

The Court understands the quagmire of ERISA jurisprudence facing the plaintiff, and it is not unsympathetic to the plaintiff's complaint that ERISA

should not deprive it of its claim. The caselaw makes clear, however, that the plaintiff is not the only potential plaintiff who has faced this statutory deprivation. The fact that the statute leaves the plaintiff without a remedy, "vague notions of a statute's 'basic purpose' are nonetheless inadequate to overcome the words of its text regarding the *specific* issue under consideration." *Great-West, 534 U.S. at 220,* quoting *Mertens v. Hewitt Associates, 508 U.S. 248, 261, 124 L. Ed. 2d 161, 113 S. Ct. 2063 (1993).* As stated by the Supreme Court in Great-West, in the very same section of ERISA as *Section 1132(a)(3),* Congress authorized a participant or beneficiary to bring a civil action without reference to whether the relief sought is legal or equitable. *29 U.S.C. § 1132(a)(1)(B).* "But Congress did not extend the same authorization to others. Rather, *[§ 1132(a)(3)]*, by its terms, only allows for equitable relief. We will not attempt to adjust the "carefully crafted and detailed enforcement scheme" embodied [*7] in the text that Congress has adopted. Because petitioners are seeking legal relief--the imposition of personal liability on respondents for a contractual obligation to pay money-- *[§ 1132(a)(3)]* does not authorize this action." *Great-West, 534 U.S. at 221.*

Accordingly,

IT IS ORDERED that the motion for partial summary judgment and alternatively, for declaratory relief filed by the plaintiff, Bank of Louisiana is DENIED.

IT IS FURTHER ORDERED that the motion for summary judgment filed by Aetna US Healthcare, Inc. and Aetna Life Insurance Company is GRANTED.

New Orleans, Louisiana, this 8th day of September, 2004.

HELEN G. BERRIGAN

UNITED STATES DISTRICT JUDGE

Footnotes

n1 The plaintiff previously filed a Second Amended Complaint. (Rec. Doc. 4).

n2 In the pre-trial order subsequently entered into the record, the plaintiff includes all dismissed claims, making a meaningful discussion of the plaintiff's remaining claims difficult. (Rec. Doc. 103). Similarly, in BOL's motion, it does not identify or discuss the nature of the remaining ERISA claims.

n3 The Court notes that BOL's extensive citation to *Roark v. Humana, Inc., 307 F.3d 298 (5th Cir. 2002)* may be misplaced. That case, although that case was settled at the Supreme Court, its holding was recently reversed by *Aetna Health, Inc. v. Davila, 542 U.S. 200, 159 L. Ed. 2d 312, 124 S. Ct. 2488 (2004).*

n4 Under *U.S.C. § 1002*, the term "participant" "means any employee or former employee of an employer ... who is or may become eligible to receive a benefit of any type from an employee benefit plan ..." The term "beneficiary" is defined as "a person designated by a participant or by the terms of an employee benefit plan, who is or may be entitled to a benefit thereunder ..."

n5 Under *Section 1002*, "employer" "means any person acting directly as an employer or indirectly in the interest of an employer, in relation to an employee benefit plan ..."

*Section 1132(a)(3)* allows for "appropriate equitable relief" for a "participant, beneficiary or fiduciary," and has been the subject of much jurisprudence distinguishing between legal and equitable relief, including Great-West. This section is a "catchall provision" that "acts as a safety net, offering appropriate equitable relief for injuries caused by violations that *[§ 1132]* does not elsewhere adequately remedy."*Varity Corp. v. Howe, 516 U.S. 489, 512, 134 L. Ed. 2d 130, 116 S. Ct. 1065 (1996).*

The Court notes that *Section 1132(a)(8)* provides that "[a] civil action may be brought ... by an employer ... to obtain appropriate equitable relief ..." with regard to *29 U.S.C. § 1021(f)(1)*, which is now-repealed reporting requirements. No other provision of *Section 1132* provides an employer with a right to bring a civil action.

Under *29 U.S.C. § 1132(e)*, federal district courts have "exclusive jurisdiction of civil actions ... brought by a participant, beneficiary, fiduciary, or any person referred to in *Section 1021(f)(1)*," except for those claims brought by participants or beneficiaries to recover benefits due.

CIVIL ACTION NO. 02-236 SECTION "C" (5)

UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF LOUISIANA

BANK OF LOUISIANA

VERSUS

AETNA US HEALTHCARE, INC., ET AL

**July 9, 2003, Decided**
**July 9, 2003, Filed, Entered**

**COUNSEL:** For BANK OF LOUISIANA, plaintiff: Henry L. Klein, Henry L. Klein Attorney at Law, Maria Nan Alessandra, Phelps Dunbar, LLP, James Harold Daigle, Jr., Klein Daigle, LLC, New Orleans, LA.

For AETNA US HEALTHCARE, INC., AETNA LIFE INSURANCE COMPANY, defendants: Richard G. Duplantier, Jr., John L. Fontenot, Jr., Galloway, Johnson, Tompkins, Burr & Smith, New Orleans, LA.

**JUDGES:** HELEN C. BERRIGAN, UNITED STATES DISTRICT JUDGE.

**OPINION BY:** HELEN C. BERRIGAN

**OPINION:**

ORDER AND REASONS

This matter comes before the Court to determine the law applicable to the plaintiff's claims. Having

considered the record, the memoranda of counsel and the law, the Court has determined that the plaintiff's claims are preempted by the Employee Retirement Income Security Act, *29 U.S.C. § 1001* ("ERISA") for the following reasons.

The plaintiff, Bank of Louisiana ("BOL"), filed this diversity suit against Aetna US Healthcare, Inc. and Aetna Life Insurance Company (collectively "Aetna") seeking the reimbursement of funds for claims made by BOL employees under an Aetna policy. In its complaint, BOL made four state law claims: (1) misrepresentation; (2) detrimental reliance; (3) breach of contract; and (4) breach of fiduciary duty.[1] The issue of ERISA preemption was briefed on order of the Court. In its memoranda, the plaintiff identifies an additional claim under *La. Rev. Stat. 22:657*, which has never been pleaded,[2] and claims that it is a viable claim along with the claims for detrimental reliance and/or negligent misrepresentation. (Rec. Doc. 64, Rec. Doc. 70, p. 2).

There are two types of ERISA preemption: complete preemption under *29 U.S.C. 1132* ("Section 502") and conflict preemption under *29 U.S.C. § 1144* ("Section 514"). *Roark v. Humana, Inc., 307 F.3d 298, 305 (5th Cir. 2002)*. Complete preemption exists where the state law duplicates or falls within the scope of an *ERISA § 502* remedy; it can provide subject matter jurisdiction in this Court. Id. Conflict preemption under *Section 514* is provided where state laws "relate to" ERISA plans, but serves only as a defense and does not confer original or removal jurisdiction in federal court. n3 Id. The plaintiff and the defendant appear to agree that this case does not present claims under *Section*

*502*. Therefore, the Court's preemption analysis turns to *Section 514*.

The "general preemption clause" of *Section 514(a)* provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" governed by ERISA.[4] This definition receives broad jurisprudential interpretation. *CIGNA Healthplan of Louisiana, Inc. v. State of Louisiana, 82 F.3d 642 (5th Cir.)*, cert. Denied, *519 U.S. 964, 136 L. Ed. 2d 304, 117 S. Ct. 387 (1996)*. In order to "relate to" a plan, a state law claim must have "a connection with or reference to such plan." *Shaw v. Delta Air Lines, Inc., 463 U.S. 85 96-97, 77 L. Ed. 2d 490, 103 S. Ct. 2890 (1983)*; *Rozzell v. Security Services, Inc., 38 F.3d 819, 821 (1994)*. There is no real issue that the claims made by BOL against Blue Cross "relate to" a covered plan for present purposes.

In order to be preempted by ERISA, the state law claim must also (1) address an area of exclusive federal concern, and (2) directly affect the relationship between the traditional ERISA entities: the employer, the plan and its fiduciaries, and the participants and beneficiaries. *Reliable Home Health Care v. Union Central Insurance Co., 295 F.3d 505, 515 (5th Cir. 2002)*. The Court finds that all of the plaintiff's state law claims set forth in the complaint are preempted under *Section 514(a)*. The parties are two traditional ERISA entities: the employer and the plan insurer. The claims all pertain to the terms of an ERISA-governed plan and will require the examination of plan terms. Such plan interpretation has been found to be sufficient to warrant ERISA preemption. *Christopher v. Mobil Oil Corp., 950 F.2d 1209, 1218 (5th Cir.)*, cert. denied, *506 U.S. 820, 121 L. Ed. 2d 35, 113 S. Ct. 68 (1992)*. The

necessary examination of policy language or amendment terms warrant preemption in light of the expansiveness of *Section 514(a)*; "the underlying conduct alleged by [plaintiff] cannot be severed from its connection to the Plan." *Reliable, 295 F.3d at 516.*

This conclusion comports with the rule that "preempted state law includes any state law cause of action as it relates to an employee benefit plan, even if it arises under a general law which in and of itself has no connection to employee benefit plans." *Christopher, 950 F.2d at 1219.* Specific state law claims which have been preempted include fraud, civil conspiracy, breach of contract, interference with contract rights, negligence, gross negligence, *Christopher, supra,* fraud and negligent misrepresentation, *Lee v. E. I. DuPont de Nemours & Co., 894 F.2d 755 (5th Cir. 1990).*

The Court finds no reason to except the plaintiff's state law claims for detrimental reliance and misrepresentation from preemption, since they meet both prongs of the test. In arguing against preemption, the plaintiff erroneously relies on the rule established in cases where an independent third-party provider sues the plan for misrepresenting the insured status of a patient prior to providing medical services. See e.g., *Jefferson Parish Hospital v. Principal Health Care of Louisiana, 934 F. Supp. 206 (E.D.La. 1996)*; *Jefferson Parish Hospital v. Central States Southeast & Southwest Areas Health & Welfare Fund, 814 F. Supp. 25 (E.D.La. 1993).* A health care provider is not a "traditional ERISA entity" for purposes of the preemption analysis.

In its memoranda, the plaintiff singles out a claim for damages under *La. Rev. Stat. 22:657* [5] for

consideration under the "savings clause" in *Section 514(b)(2)(A)*. That clause provides that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." The Supreme Court recently restated the test which determines whether a state law qualifies for saving from ERISA preemption. "First, the state law must be specifically directed toward entities engaged in insurance ... Second, as explained above, the state law must substantially affect the risk pooling arrangement between the insurer and the insured. *Kentucky Ass'n of Health Plans, Inc. v. Miller, U.S. , 155 L. Ed. 2d 468, 123 S. Ct. 1471, 1479 (2003)*.

Here, there is no dispute that *La. Rev. Stat. § 22:657* is directed toward entities engaged in insurance for purposes of the first prong of the *Kentucky* test. The Supreme Court explained the second element:

> We emphasize that conditions on the right to engage in the business of insurance must also substantially affect the risk pooling arrangement between the insurer and the insured to be covered by ERISA's savings clause. Otherwise any state law aimed at insurance companies could be deemed a law that "regulates insurance," contrary to out interpretation.

*Kentucky, 123 S. Ct. at 1477*. Here, the Court can not find that *Section 22:657* "substantially affects the risk pooling arrangement between insurer and insured" for purposes of the savings clause. The statute merely provides additional penalties for late payment. This

finding is in conformity with the caselaw: "almost all of the cases addressing the issue hold that 22:657 is subject to ordinary preemption under *ERISA section 514* ... Notably, many of these cases specifically find that *Section 22:657* is preempted because it creates an alternative remedy that is not authorized under ERISA's civil enforcement scheme." *Arana v. Ochsner Health Plan, 302 F.3d 462, 473 (5th Cir. 2002)*, reh'g en banc granted, *319 F.3d 205 (2003)* (internal citations omitted). See also, *Anderson v. Business Men's Assurance Co., 2003 U.S. Dist. LEXIS 9833, 2003 WL 21305335 (E.D.La.)* (J. Fallon); *Clancy v. Employers Health Ins. Co., 101 F. Supp. 2d 463 (E.D.La. 2000)* (J. Clement).

This Court agrees that, in addition, *Section 22:657* would be among the state laws that are incompatible with ERISA because it adds a judicial remedy that is not available under ERISA. Such supplementation has been found to "patently violates ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 379, 153 L. Ed. 2d 375, 122 S. Ct. 2151 (2002).*

Accordingly,

IT IS ORDERED that the plaintiff's state law claims for (1) misrepresentation, (2) detrimental reliance, and (3) violation of *La. Rev. Stat. § 22:657* are DISMISSED as PREEMPTED by ERISA, and the plaintiff's claims for (4) breach of contract, (5) violations of *La. Rev. Stat. § 22:658* and *§ 22:1220*, and (6) breach of fiduciary duty are DISMISSED as abandoned. This

dismissal shall take effect in ten days, in order to allow the plaintiff an opportunity to amend its complaint, if appropriate.

**The parties are encouraged to pursue amicable resolution.**

New Orleans, Louisiana, this 9th day of July, 2003.

HELEN G. BERRIGAN

UNITED STATES DISTRICT JUDGE

Footnotes

n1 The plaintiff has indicated its intention to withdraw the claim for breach of fiduciary duty. (Rec. Doc. 64, p. 3, fn. 2). The plaintiff does not mention the state law breach of contract claim in the memoranda, and the Court deems this claims abandoned.

n2 The plaintiff has pled in an amended complaint a claim under *22:658 and 22:1220*, which it does not discuss in its memoranda. (Rec. Doc. 3). The Court assumes that the plaintiff intends to abandon such claims; in the event it intends to present the same argument as made with regard to *La. Rev. Stat. 22:657*, those claims would be preempted for the reasons set forth hereinafter.

n3 Subject matter jurisdiction is not an issue here, in light of the existence of diversity jurisdiction.

n4 The parties apparently agree that the Blue Cross policy was an employee benefit plan covered by ERISA.

n5 *Section 22:657* provides for a penalty double the amount of benefits due plus attorney's fees for an

insurer's unreasonable failure to pay a claim within 30 days from receipt of written notice and proof of claim.

No. 04-30986

UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BANK OF LOUISIANA,

Plaintiff-Appellant,

versus

AETNA US HEALTHCARE INC; AETNA LIFE INSURANCE COMPANY,

Defendants-Appellees.

**October 18, 2006, Filed**

**JUDGES:** Before REAVLEY, GARZA, and BENAVIDES, Circuit Judges.

**OPINION BY:** EMILIO M. GARZA

**OPINION:** EMILIO M. GARZA, Circuit Judge:

In response to the Petition for Rehearing filed by defendants Aetna US Healthcare Inc. and Aetna Life Insurance Company, and having duly considered the response and the reply, we withdraw the prior panel opinion, *459 F.3d 610*, in its entirety and substitute the following:

The Bank of Louisiana ("the Bank") appeals a summary judgment for the defendants Aetna US Healthcare Inc. and Aetna Life Insurance Company (collectively "Aetna"). The issue on appeal is whether

the Bank's state law claims of detrimental reliance, breach of contract, and misrepresentation are preempted by the Employee Retirement Income Security Act, *29 U.S.C. § 1001 et seq.* ("ERISA").

I

In 1995, the Bank entered into two contracts with Aetna. First, the Bank entered into an administrative services contract ("ASC") with Aetna to administer the Bank's self-insured employee benefit plan ("the Plan").[1] Second, the Bank purchased from Aetna a stop-loss insurance policy for the Plan.[2] The stop-loss policy provided an "individual" or "specific stop-loss amount" of $ 50,000 and an "aggregate stop-loss amount" of $ 600,000.[3] The stop-loss coverage was scheduled to terminate on December 31, 2000.

The Bank, however, reached the aggregate stop-loss amount in 2000. Late in that year, the parties met to form a new contract that would provide fully-insured coverage commencing on January 1, 2001. The Bank also purchased an extension on its stop-loss coverage that would apply to claims incurred in 2000 and for which benefits would be paid during the first three months of 2001. In a letter from account representative Stacy McMahon, Aetna stated that the stop-loss extension would mean that the Bank would "have no additional claim liabilities for 2000 and no additional fund transfers [would] be requested." McMahon further stated that Aetna would "start wiring [the Bank's] account for claims paid during the runoff period and [the Bank would] be reimbursed at year-end." During the three month run-off period, the Bank submitted $ 271,628.38 in net claims incurred by plan members in 2000. (R. 177, 181, 218, 243.) Aetna drafted the Bank's

account for these claims over the course of 2001 and 2002. Five of these drafts occurred during the three-month stop-loss extension period, totaling $ 102,720.06. Nevertheless, Aetna declined to reimburse the Bank.

The Bank filed a complaint alleging that Aetna had negligently or fraudulently misrepresented that, pursuant to the stop-loss extension, Aetna would reimburse the Bank for the $ 271,628.38 that it drafted from the Bank's account. In particular, the Bank first claimed that Aetna "misrepresented the value and benefit of its payment" to Aetna for the extension to the stop-loss policy. Second, the Bank alleged that Aetna misrepresented the scope of the stop-loss extension and that the Bank had detrimentally relied on these representations. Third, the Bank alleged that Aetna breached "express and implied contracts," including a contract to reimburse the Bank for claims that were paid or should have been paid during the three-month extension period. Fourth, the Bank alleged that Aetna breached its fiduciary duties as plan administrator by administering the Plan "in such a fashion as to delay the processing of claims" in order to remove them from coverage under the stop-loss extension. Finally, in an amended complaint, the Bank alleged that Aetna had violated *Louisiana Revised Statutes 22:658*[4] and *22:1220*.[5]

Aetna moved for summary judgment on the ground that the Bank's claims were preempted by ERISA. In a series of briefs, Aetna argued that ERISA preempted claims between an employer and a plan administrator. (R. 930.) The Bank responded that its claim of detrimental reliance and a claim for attorney's fees under *Louisiana Revised Statute 22:657*, the latter of which it had not pled,[6] were not preempted because

they exclusively involved parties providing services to an ERISA plan in a non-fiduciary capacity. (R. 635, 882.) The Bank withdrew its breach of fiduciary duty claim[7] and abandoned its claims under *Louisiana Revised Statute 22:658 & 22:1220.* The district court held that ERISA preempted all of the Bank's remaining claims and granted summary judgment for Aetna.

II

In reviewing a summary judgment, we apply the same standard as the district court. *Martin v. Alamo Community Coll. Dist., 353 F.3d 409, 412 (5th Cir. 2003).* We affirm only if there is no genuine issue of material fact and the movant is entitled to judgment as a matter of law. *Id.* For a defendant to obtain summary judgment on an affirmative defense, it must establish beyond dispute all of the defense's essential elements. *Id.* We review the district court's legal determination that ERISA preempts a state law claim *de novo. Bullock v. Equitable Life Assurance Soc'y of the United States, 259 F.3d 395, 399 (5th Cir. 2001).*

A

ERISA's preemption clause, *29 U.S.C. § 1144(a),* states that with certain exceptions, ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." The Supreme Court has "observed repeatedly that this broadly worded provision is 'clearly expansive.' " *Egelhoff v. Egelhoff ex rel. Breiner, 532 U.S. 141, 146, 121 S. Ct. 1322, 149 L. Ed. 2d 264 (2001)* (quoting *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995)).* The Court has held that a

state law "relates to an ERISA plan 'if it has a connection with or reference to such a plan.' " *Id. at 147* (quoting *Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 97, 103 S. Ct. 2890, 77 L. Ed. 2d 490 (1983)).* Simultaneously, however, the Court recognizes that, given its broadest reading, the phrase "relate to" would encompass virtually all state law, and that its "connection with" and "reference to" interpretations are "scarcely more restrictive." *Id. at 146-47.* The Court has, therefore, declined to apply an "uncritical literalism" to the phrase and instead takes the "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." *Id. at 147* (internal quotation marks omitted).

> Congress's objectives in enacting ERISA were to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing appropriate remedies, sanctions, and ready access to the Federal courts.

*29 U.S.C. § 1001(b).* To this end, ERISA's preemption provision is intended "to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Egelhoff, 532 U.S. at 148* (quoting *Fort Halifax Packing Co. v. Coyne, 482 U.S. 1,*

*9, 107 S. Ct. 2211, 96 L. Ed. 2d 1 (1987))*. A uniform administrative scheme serves to minimize administrative and financial burdens by avoiding the need to tailor plans to the peculiarities of the law of each state. *Ingersoll-Rand Co. v. McClendon, 498 U.S 133, 142, 111 S. Ct. 478, 112 L. Ed. 2d 474 (1990)*.

In light of these statutory objectives, this court applies a two-prong test to the defense of ERISA preemption. A defendant pleading preemption must prove that: (1) the claim "addresses an area of exclusive federal concern, such as the right to receive benefits under the terms of the Plan; and (2) the claim directly affects the relationship among traditional ERISA entities--the employer, the plan and its fiduciaries, and the participants and beneficiaries." *Mayeaux v. La. Health Serv. and Indem. Co., 376 F.3d 420, 432 (5th Cir. 2004)*. Because ERISA preemption is an affirmative defense, Aetna bears the burden of proof on both elements. *See Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 63, 107 S. Ct. 1542, 95 L. Ed. 2d 55 (1987)* (ERISA preemption is a defense); *Settles v. Golden Rule Ins. Co., 927 F.2d 505, 508 (10th Cir. 1991)* (defendant bears burden of proving ERISA preemption); *Kanne v. Conn. Gen. Life Ins. Co., 867 F.2d 489, 492 n.4 (9th Cir. 1988)* (same).

Aetna argues that the Bank's claims require inquiry into the administration of the Plan--an area of exclusive federal concern--because some of the drafts on the Bank's account were for benefit claims paid after the stop-loss extension expired. Aetna contends that the Bank intends to prove that these drafts nonetheless fall within the stop-loss extension because they arise from benefit claims that Aetna improperly delayed processing. To the extent that the Bank intends to

prove its breach of contract claim through evidence that Aetna improperly delayed processing and paying benefit claims, Aetna is correct that it would require inquiry into an area of exclusive federal concern. *See Hollis v. Provident Life and Accident Ins. Co., 259 F.3d 410, 414 (5th Cir. 2001)* (right to receive benefits under an ERISA plan is an area of exclusive federal concern); *Hubbard v. Blue Cross & Blue Shield Ass'n, 42 F.3d 942, 946 (5th Cir. 1995)* (claim that would require inquiry into how benefit claims were processed implicates area of federal concern).

The Bank has asserted, however, several other claims that do not require inquiry into Aetna's processing of benefit claims or administration of the Plan. For example, to the extent the Bank's breach of contract claim is premised on Aetna's failure to reimburse it for amounts actually paid during the three-month extension period, the claim does not depend on proof that Aetna improperly delayed paying and processing benefit claims. Likewise, the Bank has asserted detrimental reliance and misrepresentation claims based on Aetna's conduct in negotiating the stop-loss extension with the Bank. These claims do not challenge any act or omission by Aetna in processing benefit claims or administering the Plan; rather, they call into question Aetna's representations about the scope of the stop-loss extension. The Bank need not prove that Aetna improperly administered the Plan in order to prevail on any of these claims.[8] Accordingly, Aetna has established the first element of the defense of preemption as a matter of law only on the Bank's claim that Aetna breached the stop-loss extension by failing to reimburse the Bank for amounts the Bank contends should have been, but were not, paid during

the three-month extension period, *i.e.*, by delaying the processing and paying of claims for benefits.[9]

Aetna argues that the second element of its defense is satisfied as a matter of law because the parties are two traditional ERISA entities--an employer and a plan administrator. The Bank contends, however, that Aetna was acting in its capacity as a vendor of insurance, not as a fiduciary of the Plan. For purposes of ERISA preemption the critical distinction is not whether the parties to a claim are traditional ERISA entities in some capacity, but instead whether the relevant state law affects an aspect of the relationship that is comprehensively regulated by ERISA. As we have noted, ERISA may preempt some claims between traditional ERISA entities but not others.[10] And a party may qualify as an ERISA fiduciary with regard to some claims but not others. *See Pegram v. Herdrich, 530 U.S. 211, 225-26, 120 S. Ct. 2143, 147 L. Ed. 2d 164 (2000)* (ERISA defines party as fiduciary "only 'to the extent' that he acts in such a capacity in relation to a plan") (quoting *29 U.S.C. § 1002(21)(A)*). "[T]he critical determination [is] whether the claim itself created a relationship between the plaintiff and defendant that is so intertwined with an ERISA plan that it cannot be separated." *Hobson, 75 Fed.Appx. at 954.*

Aetna argues that it is an ERISA fiduciary because the Bank has delegated to it the discretionary responsibility to administer the Plan.[11] The Bank correctly contends, however, that Aetna was not acting in a fiduciary capacity when it negotiated the stop-loss extension, represented to the Bank which claims would be covered by the stop-loss extension, and performed its duties under the stop-loss extension. Aetna identifies no cases holding that a stop-loss insurer is

necessarily a plan fiduciary.[12] The benefits of stop-loss insurance inure solely to the Bank, and Aetna cites no evidence that the stop-loss policy is a plan asset or was purchased with plan assets. *Cf.* DEPARTMENT OF LABOR ADVISORY OPINION 92-02A, *available at* 1992 WL 15175 (stop-loss policy is not a plan asset). *But cf. Patelco Credit Union v. Sahni, 262 F.3d 897, 908 (9th Cir. 2001)* (checks for stop-loss benefits are plan assets). Nor does Aetna identify any cases holding that a plan administrator who also brokers or negotiates a stop-loss insurance policy does so in its capacity as a fiduciary. The only claim to implicate Aetna's fiduciary relationship with the Bank is the Bank's claim that Aetna breached the stop-loss extension by failing to reimburse the Bank for claims that Aetna delayed processing and paying and, hence, that were not paid during the extension period. Accordingly, Aetna has established the second element of its preemption defense only as to this latter claim.[13]

III

For the foregoing reasons, we reverse the district court's grant of summary judgment on the Bank's claims of detrimental reliance and misrepresentation, as well as the Bank's breach of contract claim based on Aetna's failure to reimburse the Bank for benefit claims that were actually paid during the extension period; affirm the grant of summary judgment on the Bank's breach of contract claim based on Aetna's failure to reimburse the Bank for benefit claims that were not paid during the extension period and the Banks's *Louisiana Revised Statute 22:657* claim; and remand for proceedings not inconsistent with this opinion.

AFFIRMED IN PART, REVERSED IN PART, AND REMANDED.

Footnotes

n1 The parties do not dispute that this qualifies as an ERISA plan. *See 29 U.S.C. § 1002(1)* (defining employee welfare benefit plans subject to ERISA).

n2 On appeal, Aetna, for the first time, seeks to distinguish among the various Aetna entities involved in this dispute. Specifically, Aetna asserts that Aetna Life Insurance Company, which operates under the registered trade name "Aetna U.S. Healthcare," is the party whom the Bank contracted to administer the Plan; that Aetna Casualty Company, now known as Aetna Insurance Company of Connecticut--which is not a party to this suit--is the party who issued the stop-loss insurance policy for the Plan; and that Aetna U.S. Healthcare, Inc., although named by the Bank as a defendant in this suit, is a separate foreign corporation that has no connection to the Plan. Therefore, Aetna argues, at issue in this case are only claims by an ERISA employer against an ERISA plan administrator.

Aetna did not raise this argument in the district court. To the contrary, Aetna repeatedly represented in its pleadings that the Bank entered into the ASC with "Aetna" and that "Aetna" issued the Policy to the Bank. (R. 5, 657, 847, 926-27, 944, 1116-17, 1494-95, 1502.) Accordingly, we do not reach Aetna's new contention that it is not the stop-loss insurer. *See Theriot v. Parish of Jefferson,185 F.3d 477, 491 n.26 (5th Cir. 1999)* ("An appellate court . . . may not consider facts which were

not before the district court at the time of the challenged ruling.").

n3 The distinction between an individual or specific stop-loss amount and the aggregate stop-loss amount is described in Troy Paredes, Note, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption, 34 HARV. J. LEGIS. 233, 249 (1997)*, as follows:

> There are two types of stop-loss insurance. Specific stop-loss insurance covers a plan against the risk that a particular participant's claims will exceed some specified level. For example, if the insurance kicks in when an individual's claims exceed $ 20,000 per year and a participant has bona fide claims of $ 30,000, the plan's stop-loss insurer covers $ 10,000 of the person's claims. Alternatively, aggregate stop-loss insurance covers a plan against the risk that the sum of all of its participants' claims will exceed some specified level. For example, if the insurance kicks in when aggregate claims exceed $ 2 million per year and claims under the plan total $ 2.5 million, the stop-loss insurer covers $ 500,000 of the claims.

*See also* Dennis K. Schaeffer, Comment, *Insuring the Protection of ERISA Plan Participants: ERISA Preemption and the Government's Duty to Regulate Self-Insured Health Plans, 47 BUFF. L. REV. 1085, 1108-09 (1999)* (discussing difference).

n4 *Louisiana Revised Statute 22:658* requires insurers issuing certain types of policies to pay the amount of claims due within thirty days of proof of the loss.

n5 *Louisiana Revised Statute 22:1220* imposes upon insurers a duty of good faith and fair dealing.

n6 *Louisiana Revised Statute 22:657* provides that claim arising under the terms of health and accident contracts must be paid within thirty days of the date that the insurer receives written notice and proof of the claim. Failure to comply renders the insurer liable for penalties and attorney's fees. Aetna does not argue that the Bank's failure to properly plead this claim warrants affirmance.

n7 *See* District Court's Order and Reasons at 2 n.1 (July 9, 2003) (noting that the Bank had "indicated its intention to withdraw the breach of fiduciary duty claim"); Bank of Louisiana's Memorandum Regarding ERISA Preemption at 3 n.2 (Apr. 23, 2003) ("[W]e concede that BOL's Count Four, claiming breach of fiduciary duty, may be preempted by ERISA. Because the Count adds nothing to the gravamen of BOL's complaint, we will withdraw that Count without prejudice.").

Because the Bank has withdrawn its claim that Aetna delayed paying health care benefits, and a default to perform the stop-loss policy is not covered by the statute, the Bank's claim for attorney's fees under *Louisiana Revised Statute 22:657* fails.

n8 Aetna argues that the Bank cannot prevail on these theories for a variety of reasons, but the Bank's likelihood of success on the merits has no bearing on whether the claims are preempted by ERISA, which is the sole issue before this Court.

n9 Although the district court concluded that the claims implicate an area of exclusive federal concern because they "all pertain to the terms of an ERISA-governed

plan and will require the examination of the plan terms," there is nothing in the summary judgment record to support that conclusion. Neither Aetna nor the district court identified what portion of the Plan or ASC is in dispute. *Cf. Perkins v. Time Ins. Co., 898 F.2d 470, 473 (5th Cir. 1990)* (claim for fraud and misrepresentation in the procurement of an ERISA plan are not preempted).

n10 *See Hobson v. Robinson, 75 Fed.Appx. 949, 955 (5th Cir. 2003)* (unpublished) (party may be a fiduciary with regard to some claims but not others); *Smith v. Tex. Children's Hosp., 84 F.3d 152 (5th Cir. 1996)* (fraudulent inducement claim against employer not preempted while breach of contract claim was preempted); *Hook v. Morrison Milling Co., 38 F.3d 776, 783 (5th Cir. 1994)* (ERISA does not preempt all state law claims between an employee and an employer, merely because the employer administers an ERISA plan to which the employee belongs); *Sommers Drug Stores Co. v. Employee Profit Sharing Trust, 793 F.2d 1456 (5th Cir. 1986)* (claim for common law breach of corporate fiduciary duty was not preempted by ERISA, even though the defendant/corporate director was an ERISA plan fiduciary and the plaintiffs/employees were plan beneficiaries).

n11 A party acts in a fiduciary capacity when he: 1) exercises discretionary control over plan assets; 2) he renders investment advice for a fee to the plan; or 3) he has discretionary responsibility with regard to plan administration. *29 U.S.C. § 1002(21)(A)*; *see also Tri-State Mach., Inc. v. Nationwide Life Ins. Co., 33 F.3d 309, 313-14 (4th Cir. 1994)* (claims by employer against plan administrator and stop-loss insurer for delaying the processing of claims are preempted); *Iron Workers*

*Mid-South Pension Fund v. Terotechnology Corp., 891 F.2d 548, 553 (5th Cir. 1990)* ("the state law is preempted by *section 514(a)* if the conduct sought to be regulated by the state law is 'part of the administration of an employee benefit plan' " (quoting *Martori Bros. Distrib. v. James-Massengale, 781 F.2d 1349, 1358 (9th Cir. 1986))).

n12 The majority of cases are to the contrary. For example, the Ninth Circuit held in *Geweke Ford v. St. Joseph's Omni Preferred Care Inc., 130 F.3d 1355 (9th Cir. 1997)*, that a plan's relationship to its stop-loss insurer is like that between any commercial entities and is not regulated by ERISA. *See also Seneca Beverage Corp. v. HealthNow N.Y., Inc., 383 F. Supp. 2d 413, 423 (W.D.N.Y. 2005)* (stop-loss insurer is not a fiduciary); *Northern Kare Facilities/Kingdom Kare, LLC v. Benefirst LLC, 344 F. Supp. 2d 283, 287 (D.Mass. 2004)* (same); *Deeter v. Greene, Tween and Co., Inc., 1998 U.S. Dist. LEXIS 14625, CIV. A. 98-1222, 1998 WL 639190 (E.D. Pa. Sept. 18, 1998)* (same); *Union Health Care, Inc. v. John Alden Life Ins. Co., 908 F. Supp. 429, 432-36 (S.D. Miss. 1995)* (same). The reasoning of these courts is persuasive and consistent with our own.

n13 Aetna relies on *Tri-State Machine, Inc. v. Nationwide Life Insurance Co., 33 F.3d 309 (4th Cir. 1994)*, but that case is not to the contrary. Tri-State Machine, an employer, sued Nationwide Life Insurance, the administrator and stop-loss insurer for its ERISA plan. Tri-State alleged that Nationwide Life "delayed processing claims in years when the stop-loss limit had been reached in order to deflect them into a new policy year to be charged against Tri-State under its self-funding obligations." *Id. at 314*. The Fourth Circuit held

that such an allegation was essentially a challenge to a plan administrator's processing of claims and therefore related to the plan. *Id.* Likewise, the Bank's breach of contract claim, to the extent it is premised on Aetna's alleged delaying the processing of claims, is preempted. The wrong for which the Bank seeks to recover in its remaining claims, however, is Aetna's conduct in negotiating and performing under the stop-loss extension. Such claims do not concern the processing of claims for benefits and are not preempted.

The Fourth Circuit's cases are consistent with our reasoning that the parties are not fiduciaries with respect to the Bank's surviving claims. In *Phelps v. C.T. Enterprises, Inc., 394 F.3d 213, 219 (4th Cir. 2005)*, the court "emphasized that fiduciary duty under ERISA is not an all-or-nothing concept." *See also Cotton v. Mass. Mutual Life Ins. Co., 402 F.3d 1267, 1277 (11th Cir. 2005)* (fiduciary status under ERISA not an "all-or-nothing concept").

*Broadnax Mills, Inc. v. Blue Cross and Blue Shield of Virginia, 867 F. Supp. 398 (E.D. Va. 1994)*, is also distinguishable. The employer in *Broadnax Mills* sued the plan administrator and stop-loss insurer on the ground that it negligently failed to advise it to obtain an aggregate stop-loss policy and breached the Plan's Administrative Service Agreement. In *Broadnax Mills*, it was conceded that the stop-loss insurance was purchased by funds contributed by plan participants and therefore concerned the disposal of plan assets. *See id. at 403.* Aetna points to no similar concession in this case. The plaintiff in *Broadnax Mills* also alleged that the plan administrator breached its duty to disclose and report the financial status of the plan. *Id. at 403-04.* The Bank's claims do not involve similar allegations.